CAUTHORN (F.)

Success removal of a large tumor xxxxxxx

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SUCCESSFUL REMOVAL OF A LARGE TUMOR OF THE MESENTERY, WITH RESECTION OF 43 INCHES OF INTESTINE; END-TO-END ANASTOMOSIS WITH MURPHY BUTTON.

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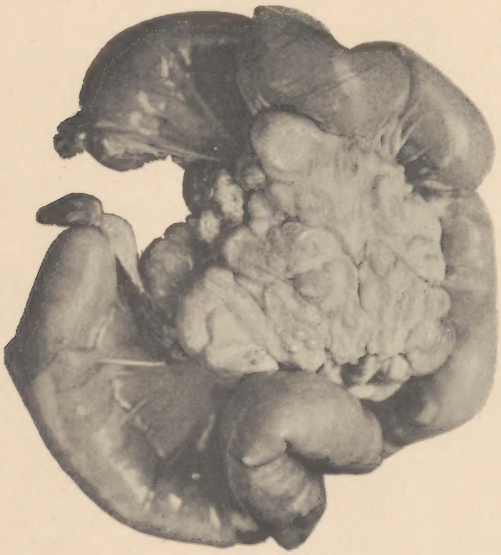
M. P. T., aged forty-nine years, a farmer, was brought to Portland Hospital, January 16, 1895, for operation, by Dr. G. W. Maston, of Albany, with whom I saw him in consultation. Dr. Maston had noticed for about three years the presence of a hard tumor in the abdomen, which had grown more rapidly in the last three months, until it was now approximately the size of a double fist. A diagnosis of solid tumor, probably malignant, of the mesentery was made, and an exploratory operation was agreed upon and was performed the next day, January 17, 1895. Dr. Maston made the opening into the abdomen and exposed the tumor, which could be lifted out of the abdominal wound. A careful examination revealed the intimate attachment to the tumor of a large extent of intestine. After consultation as to the feasibility of removal I proposed to Dr. Maston the resection of the intestine involved in the tumor. To this the doctor gave his consent and asked me to execute the operation, which was done with his assistance. The tumor was located in the mesentery and had encroached upon the intestine until the mesentery upon this side of

the tumor had been completely obliterated. Fortunately there was free mesentery between the tumor and the posterior mesenteric attachment. The tumor was approximately seven inches in diameter in its greatest breadth and four to five inches in its least, and of almost cartilaginous hardness. The amount of mesentery involved at its base was between six and seven inches.

The details of the operation are perhaps non essential, except in one or two particulars, and I will confine my report to these. The two points of most importance were to cut the gut where its blood-supply would not be interrupted by the extensive section of the mesentery, and to handle this extent of mesentery without excessive hemorrhage. By lifting the tumor up, and thus putting the mesentery on the stretch against the light background of a window opposite, it was rendered semi-translucent, and the bloodvessels (principally the veins, I believe) could be quite readily discerned in their course through it to and from the gut. A point was selected on each side of the tumor which this blood-supply seemed to reach, passing clear of the tumor, and was marked by passing a heavy silk ligature around the gut at this point. These ligatures were tied loosely, merely to close the caliber of the gut and to facilitate handling the ends. The gut was then cut with scissors at these points and the mesentery torn downward until clear of the base of the tumor. I can recommend this maneuver, because the tear will follow the general radiations of the mesentery, and starting right I can hardly conceive that any vessel of any importance can be torn across. With the mesentery still upon the stretch, it was cut for perhaps three-fourths of its extent across the base by successive half-inch snips of the scissors, without any hemorrhage worth mentioning. The balance of it was then ligated *en masse* with two heavy silk ligatures. The bleeding was thus effectually prevented and did not exceed one-and-one-half ounces in the whole operation. The mesentery

was stitched together with a continuous catgut suture after the usual method, and the intestine united end-to-end with the No. 4 Murphy button. The large-sized button was used because the caliber of the intestine was above the average and accommodated the button without difficulty. Thanks to Dr. Murphy, the approximation of cut intes-



tine is the simplest part of intestinal surgery. It is simply a new version of the old story of Columbus and the refractory egg. The toilet of the peritoneum was made and the abdominal wound closed by Dr. Maston. The case was reported to the Portland Medical Society on January 23d, and the resected intestine measured in the presence of the Society full 43 inches.

The accompanying illustration shows the tumor with the intestine inflated. I confess to some astonishment

when first measuring the gut, as the unfolding of the reduplications ran rapidly into feet. I had supposed I was removing about eighteen inches. The intestine resected was undoubtedly from the ileum, but just what portion I am unable to say.

The time occupied in the operation was about one hour. The patient was put to bed with a pulse of 84 and no evidence of shock. There was a reactionary temperature of 102°, but this fell to normal at the end of forty-eight hours, and subsequent progress to recovery was practically without incident worthy of mention. Flatus began to pass about twelve hours after the operation. The bowels responded to enemata given once daily until about the sixteenth day, when they began to move of their own accord. The man was allowed only water for the first two days, and then liquid food, broths, milk, etc., until about the twentieth day, after which time suitable solid food was allowed until he has now, for some time, been taking regular diet. He has, in great part, recovered his strength and weight. This is now the forty-seventh day, and we have not yet seen the button. The nurses are instructed to watch carefully for it; but considering the early passage of formed stools, I think it may have been overlooked. However, when we bear in mind one of the cases reported by Dr. Murphy in THE MEDICAL NEWS of February 9, 1895, in which the button was passed after two months, and also with the entire absence of any symptoms indicative of the presence of a button in our patient, we have every reason to hope that no complications will arise at this late date.

In the interest of statistics in the use of the Murphy button I shall, however, report any developments that may arise in the future.

SUMMARY.

The case is interesting for the following reasons:

1. The extensive amount of intestine removed, forty-

three inches, without apparent discomfort, gives us courage in this line of work, having been excelled in this country, so far as I know, only by the case of Dr. J. W. Elliot, of Boston.

2. The method described, whereby the points of section of the gut were definitely located, I think of value.

3. The ease and safety with which the mesentery may be torn in the course of the bloodvessels commend this method as superior to cutting.

4. It adds one more successful case to the already large and fast-growing record of the Murphy button.

The specimen was submitted to Dr. Everett Mingus, Professor of Surgical Pathology of the Medical Department of the Willamette University, who has returned the following report:

PORTLAND, ORE., February, 1895.

Upon examining specimen given by Dr. F. Cauthorn and taken from a tumor from the mesentery, I note the following conditions:

The specimen is firm on pressure and has a gritty resistance to the knife; that part of the specimen which corresponds to the periphery of the tumor has cyst-cavities.

Microscopically it is characterized by almost perfect uniformity in cellular construction. There are a few delicate bands of connective tissue passing in various directions through the specimen, but the fibrous tissue is an entirely subordinate element in comparison with the great mass of embryonal connective cells that make up the tumor. The embryonal connective-tissue cells are of the large spindle-cell variety, and toward the center of the tumor show degeneration; toward the periphery of the tumor there is considerable fatty tissue. The bloodvessels have no distinct walls.

From the above appearances the nature of the specimen is that of large spindle-cell sarcoma.

Respectfully, E. MINGUS.